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Sustainable Development Goal 3.8 Universal Health Coverage from global perspectives: An analysis of the health insurance policies in Rwanda, Tanzania, South Africa, and Ghana

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Abstract

Background: The paper reviewed the policy strategies of four African states (Rwanda, Tanzania, South Africa, and Ghana) towards achieving Universal Health Coverage (UHC). It found that these four countries used national or community-based health insurance schemes as vehicles or the means to achieve UHC by 2030 in the context of the global agenda (the United Nations Sustainable Development Goals (UN SDGs).

Objective: The study aimed to specifically contribute to an interrogation of health insurance policy strategies in Africa.

Methods: It reviewed relevant literature on universal health coverage in selected regions like Europe, America, the Pacific, and Asia. It then added the materials to Sub-Saharan Africa. Data was obtained from secondary sources. Included criteria were the use of words such as United Nations Sustainable Development Goals SDGs), Universal Health Coverage (UHC), health, health insurance, health insurance scheme, and World Health Organization (WHO).

Results: The findings suggest that most African states have national or community-based health insurance schemes, and most of the health insurance schemes cover a good percentage of their population. However, most health insurance schemes cover less than half of the population. For the four cases, Rwanda and Ghana are excluded from the coverage of less than 50 percent of the population. Also, the four African states spent less than 10% of their GDP on health. These indicators suggest that the pathway towards achieving UHC in Africa by 2030 may still take some more years to be realised.

Conclusion: The study concludes that funding various health insurance schemes remains a challenge. Therefore, adequate funding by the African government for health and a positive attitude towards publicly funded health services are necessary to sustain African health insurance schemes or policies.

Keywords: SDG, universal health coverage, African states, Rwanda, Tanzania, South Africa, and Ghana.

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INTRODUCTION

This article addresses the question: Is Sub-Saharan Africa on the path to universal health coverage through national/community health insurance schemes? In response to this question, the paper engages in an extensive literature review in an attempt to answer the question. Also, there were document reviews of four Sub-Saharan African countries, namely Rwanda (Central), Tanzania (Eastern), South Africa (Southern) and Ghana (Western) were engaged. These countries were selected purposely to represent the four sub-regions of Africa, namely Central, Eastern, Southern, and Western Africa. These countries are also making efforts to improve universal health coverage (UHC). The article analyses the health insurance policies of the four Sub-Saharan African countries, their policy design factors, implementation structures (implementation process) and their implementation outputs or outcomes in the context of UHC. It specifically contributes to health

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insurance policy strategies in Africa. The United Nations Sustainable Development Goal (SDG) 3.8 focuses on good health and well-being (good health and wellness or well-being of the people of the world). The United Nations is interested in the health and well-being of all people in the world and urges member states to implement SDG 3 [1]. It is important to note that this study focuses on Goal 3, which is part of the broader goals and targets (17 goals and 169 targets) ratified by the United Nations (UN) member states in 2015 to be achieved by 2030. Member states of UN action are necessary, especially policymakers, to design their health policies and make their health systems robust to promote good health and well-being (Goal 3) through health education and health systems reforms, with the ultimate goal of making healthcare services accessible to all citizens or people [3].

The World Health Organization's (WHO) 1948 constitution defines health as the state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity" [4]. Having the right state of mind is crucial, and it is not necessarily the absence of a disease/infirmity. This concept of health is used in this paper. Sustainable Development Goal 3 is one of the 17 goals set by UN member states to work with, and the hope is to achieve it by 2030. Goal 3 has nine targets for reducing the following: morbidity and mortality of vulnerable groups (target 1), preventable deaths of newborns and children under five years (target 2), to end communicable diseases-epidemics like AIDS, tuberculosis, malaria and others (target 3) and to reduce by one-third premature deaths from non-communicable diseases (target 4), risk factors like substance use, tobacco, harmful alcohol, (target 5), to reduce road traffic fatalities and injuries by half by 2020 (target 6), have access to universal sexual and reproductive health services (target 7), working towards achieving universal health coverage in terms of access to quality healthcare, affordability of healthcare, drugs/medicines and vaccines for all people by strengthening the health systems of countries across the globe (target 8), and finally, reduce the incidence of deaths and injuries from hazardous chemicals and forms of pollution - air, water, soil/environment and contamination (target 9) [5-6].

The timelines for all nine targets are very close. One of the targets (target 6) has passed (reducing road traffic fatalities and injuries by half by 2020). Time is not with UN member states to implement targets. The earlier, the better for states or countries, including those in Suh-Saharan Africa, to act right on goal 3 and the targets. The paper is interested in only one target: target 8 (universal health coverage), with emphasis on Sub-Saharan African states' efforts towards achieving target eight by 2030. In this regard, the paper engages in literature and document reviews of health insurance policy strategies of four countries, namely Rwanda, Tanzania, South Africa and Ghana, representing the four subregions of Africa (central, east, south and west respectively) on their pathways toward UHC.

MATERIALS AND METHODS

The study used largely secondary data sources from these diverse databases: Google Scholar, ResearchGate, Web of Science, and JSTOR. Also, other data used in the study were obtained from the National Health Insurance Authority website. In a few cases, the use of Google and other open search engines on universal health coverage, and states efforts towards UHC, searched and obtained various internet sources. Some of the keywords that the researcher used in the search for information or data gathering include: ‘universal health coverage’, ‘national health insurance scheme’, ‘community-based health insurance scheme’, ‘employee-based health insurance’, ‘SDG 3’, and ‘World Health Organization’. Moreover, other words including ‘challenges of UHC, ‘prospects of UHC’, and ‘politics of UHC were used to search for materials for the study. Based on these keywords, over 100 peer-reviewed journal materials, books, and a few internet sources of information were obtained. The next step was to search for those that related to the study’s objectives. Some 50 of the materials were indeed used. Some key themes emerged from the search which are presented in Table 1.

Table 1: Major themes from the secondary databases used in the study and their sources

Major themes	Key sources of information obtained from literature
Universal Health Coverage	• Ghebreyesus (2017) • World Bank (2022) • Craig et al (2022) • Kipo-Sunyehzi et al (2019) • Takura and Miura (2022) • Lagomarsino et (2012) • McKee et al (2012) • Kutzin (2013) • Michael et al (2020) • Ghanbari et al (2021)
Sustainable Development Goal 3 (SGD)	• Asi YM, Williams C. (2018) • Howden-Chapman et al (2017) • SDG (2022)
Prospects towards UHC	• Van Mah et al (2014) • Kimario, Muhanga, and Kayunze (2020)
Challenges towards UHC	• Unmeh CA. (2018) • Darrudi, Khoonsari Tajvar (2022)
Achieving UHC: a Political Choice (Politics of UHC)	• Ho et al (2022)
World Health Organization	• WHO (2005) • WHO (2022) • Kutzin et al (2017)
National Health Insurance Scheme	• Kipo-Sunyehai (2021) • Arhin (2013)
Community-based Health Insurance	• Melaka, Breen, and Binagwaho (2012) • Rwanda CBHI (2015) • Chinwa et al (2021) • Koch et al (2022)

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Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) is widely accepted by scholars, and researchers in medicine and other scientific fields for several reasons including how the review of the literature was done, why it was done so and finally what was found in the review with specific reference to the PRISMA 2020 guidelines [52-54]. It is important to note this study approach did not fit exactly into the processes of systematic reviews, as the study had less adherence to PRISMA 2020 guidelines. Though some good efforts were made for strict adherence to the 27-item PRISMA checklist, with the four-phase flow diagram, admittedly the strict adherence was low in this study. As this study rather chose a synthesising approach targeting reports, journal articles, or studies which explicitly cover these headings and whose content covers UHC and SDG 3. Outside the two criteria constitute the excluded criteria used in the search for this study materials. Thus, these are the inclusive and exclusive criteria used. The selection was based on countries with national or community-based health Insurance schemes in each of the Sub-Regions of the African Union (AU) in Sub-Saharan Africa namely Southern Africa with South Africa, Central Africa with Rwanda, East African with Tanzania and West Africa with Ghana.

LITERATURE REVIEW

Historically, UHC was used in the German context as far back as 1883, when Germany introduced UHC to take care of its teeming young population. UHC became more popular when the World Health Assembly adopted it in 2005, and subsequently, the United Nations (UN) and its agencies like the World Health Organisation (WHO) pushed member states to embrace UHC and find innovative ways of financing it. Then, by 2010, the World Health Report emphasised health systems financing for states to build on toward achieving UHC. The WHO conceptualises UHC as access to healthcare services by all people of good quality when and where they need the healthcare services without financial barriers, limitations, or hardships. These healthcare services include access to health promotion, prevention, treatment, rehabilitation and palliative care, which are available to the people in their communities [7]. UHC is the means toward achieving the two core goals of the World Bank Group: to end extreme poverty in the world and increase equity and shared prosperity, a way to build on the human capital of countries [8]. UHC has moved away from being a health issue to be tackled by those in the health sector alone. It has gained global attention with a high level of political commitment by UN member states toward achieving UHC.

One of the political commitments is the member states' decision to carry out the Global Action Plan for Healthy Lives and Well-being (GAP) in September 2019 and the second international forum in January 2020. All these efforts aim to increase UHC's political commitment. Moreover, there have been efforts of G20 members to help developing countries achieve UHC since 2019, as well as many efforts across the globe on UHC. The World Bank and WHO urge all member states to increase spending on Primary Health Care (PHC) by at least 1% of their Gross Domestic Product (GDP) effectively from 2019 towards the 2030 period set for the global agenda for UN member states [8]. UHC is about free access to healthcare services or affordable healthcare services for all people in a country, irrespective of their socioeconomic status in society, which implies health financing to address extreme poverty. Some states or countries used general tax to provide UHC, other states used national health insurance schemes, and some states used community-based health insurance schemes as pathways to UHC. UHC is the best way out of out-of-pocket payments (cash payments) at the points of health service delivery, as UHC aims to reduce extreme poverty, reduce social inequity, and effectively improve good health and the general well-being of all the people/citizens [9-11].

UHC remains a highly contestable issue as there is no single definition or conceptualisation. In the Pacific regions, the Ministers of Health adopted a five-prone approach or areas/themes toward achieving UHC. These areas or themes include unifying action for UHC, integrated primary health care at the community level, building human resources for health, having access to reliable health information, and embracing digital health for the period 2015 - 2022. The Pacific region is very much concerned with the health of the 11.4 million population found in the hundreds of islands constituting the 22 Pacific Island Countries and Territories (PICTs) [12-14]. The Pacific countries and territories are working towards the realisation of UHC within United Nations Sustainable Goal 3.8 by 2030 to make healthcare services accessible to all people (as Healthy Islands' vision). Besides the conceptual issues or problematics, UHC politics exists across the globe. The political dimension seems to be overlooked or not factored much in the conceptualisation of UHC.

Universal Health Coverager is conceptualised as the strong political will or commitment at the highest level to implement a health reform or a health policy. Thus, UHC as a concept "involves the redistribution of resources across income groups, a political process that can rouse intense contestation between different groups" (15:2066). UHC entails states' commitment to the provision of physical infrastructure and human resource development, which all involve the political process and politicians' decisions. Where there is high political commitment, it is more likely to facilitate states' efforts toward UHC than in situations where there is little or no political will or commitment toward achieving UHC. The political choice may be influenced by the ideas, interests and political institutions of a state. These three factors can facilitate or inhibit governments' moves toward UHC. Thus, the pathway to achieving UHC is a political choice of governments or countries' political authorities to accept or reject UHC, as echoed by the Director General of WHO (Ghebreyesus) [16]. Even though moving toward UHC is a political choice, in reality, it goes beyond politics to include the

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roles/support of non-state actors and individuals as well as the availability of resources. This implies that for UHC to succeed, healthcare services must be publicly funded without these payments (out-of-pocket, cash and carry, extra medical billings for patients or service users). The recent global pandemic (COVID-19) showed that everyone, and not only the poor, is susceptible [15]. Universal Health Coverage (UHC) emphasises universalism over particularism, in which every member of society benefits from access to healthcare services without hardships or limitations. Also, not just access to healthcare services but good and quality healthcare services for all [17-19]. UHC is also conceptualised in the context of the number of healthcare services that are covered by the people in a country's health system. In this regard, some studies looked at UHC from the service coverage index (SCI) as a pathway toward achieving UHC. One such study focuses on 11 Asian countries from 2015 to 2017 and the relationship between SCI and some key socioeconomic indicators like gross domestic product (GDP), lack of jobs, health expenditure, and poverty.

The study found these major socioeconomic factors to affect the countries' progress toward UHC [20]. In Sub-Saharan Africa and Asia, a similar study analyses their progress toward UHC in the context of categories of healthcare services, cost and the population covered by the national/community health insurance schemes in nine countries -five in sub-Saharan Africa and four in Asia [21]. There are still no clear-cut indicators used to measure the level of progress made by countries or states towards UHC in both developed and developing countries. However, the more the people/citizens have free/low-cost access to healthcare services (good quality), the higher expenditure on health (to cover the cost of healthcare services, drugs/medicines/ vaccines), and closer toward the entire population coverage or more than 90% population coverage are clear indicators for UHC. Among the developed countries, UHC has been achieved through a publicly funded (government) general tax system or a mix of public-private schemes or employer-based insurance schemes. The United Kingdom (UK) has free healthcare through public facilities. Also, in Germany, UHC covers public and private healthcare facilities/medical doctors and is funded through government funds (pool) to pay for healthcare services. Many other developed countries, such as Canada, Australia, New Zealand, Austria, the Netherlands, and Italy, among others, are countries with UHC through public funding mechanisms. These public (government/state) funding mechanisms include the Nordic states like Norway, Denmark, Finland, and Sweden. However, such public funding mechanisms for UHC exclude the USA [22-24]. Achieving UHC in both developed and developing countries calls for the activation of these four core functions in the health systems of states: coherent and well-designed/aligned strategy for health financing, stewardship, creation of resources and delivery of healthcare services [24-27]. See Table 1 on the search for the conceptions of UHC across the globe.

Table 2. A summary of the main conceptions of UHC across the globe

Scholarly Works	Regions	Conceptualizations of Universal Health Coverage
[7], [17-19]	Global	UHC as access to quality healthcare services for all people
[15], [16]	Global	UHC as a political choice or commitment or will of leaders
[12-14]	Pacific	UHC as accessible and affordable healthcare services for all
[20-21]	Asia	UHC from service coverage index or socio-economic factors
[17, 21]	Africa	UHC from the services, the cost and the population coverage
[22-24]	Developed Countries	UHC from public-private provision (government) funded

RESULTS

Policy design and Implementation strategies/structures in some developed countries

In the United Kingdom, the government (public) is directly involved in the provision of healthcare services to the citizens and other people in the Kingdom through the National Health Service (NHS), but with some slight differences across the four nations (England, Wales, Scotland and Northern Ireland). The NHS relies on General practitioners (GPs) to provide primary healthcare services (PHCs) to the patients, and some prescriptions may be obtained from some accredited private pharmacies even though PHCs are generally provided by the public (state-funded or financed drug reimbursement). The UK spent some 10.2% of the GDP on healthcare in 2019. In Canada and France, for instance, some healthcare services are provided by the private sector; thus, there is a public-private mix in the provision of healthcare services to the citizens and people. In this arrangement, private healthcare providers are contracted to provide some healthcare services and are reimbursed by the public authorities in charge of the health insurance scheme.

In Canada, the public-funded health insurance is called Canadian Medicare, which is decentralised. It was passed in 1984 known as the Canada Health Act of 1984. The state or publicly funded is 70%, while private sector insurance takes care of the 30% of healthcare services that are not covered by Medicare. Some of these excluded services include eye, dental, and drug prescriptions. Other forms of health insurance exist in Canada, including employer-based schemes. As of 2017, Canada spent some 11.5% of its GDP on health. Historically, Germany has the world's oldest health insurance system, which started in 1883. Health insurance was imitated and implemented through Otto von Bismarck's social legislation, the Health Insurance Bill

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1883, by a liberal-conservative politician, leader, or statesman. In Germany, there is state support for persons who earn less than targeted salaries and private health insurance schemes, which are usually attended or visited by higher salary earners or the affluent who can pay more for a private health insurance scheme or policy. The German model of health insurance is termed a multiple-payer health insurance system or healthcare system (state vs private) blend of private--statutory-government/state health insurance scheme (Gesetzliche Krankenkasse or GKV) and private health insurance (Krankenversicherung or PKV). Employees pay 7.5% out of their salaries, and employers match this 7.5% on behalf of the employees. Thus, the health insurance scheme is co-financed in Germany between employers and employees. The employers pay such premiums into the national insurance pool on behalf of their employees. The German health insurance pool operates under the principle of "all for one and one for all" (solidarity). Equal healthcare for all people irrespective of their income differences. Some 11.2 of the Gross Domestic Product (GDP) is spent on healthcare in Germany. In terms of payment mechanisms, there has been a change from a fee for service to capitation and co-payment as a measure to contain the cost of medicines/drugs and healthcare.

In Japan, historically, employee health insurance kicked off in 1927, but Japan achieved UHC in 1961 when everyone was insured. Japan's health insurance covers all the people under universal healthcare and on the principle of equality for all people. However, the patients are required to have a form of insurance and to pay some 10 to 30% of the cost while the state or government pays the remaining cost of healthcare services. Also, all must have health insurance, but a few opted out of it and are not forced. The uninsured, in principle, pay 100% except for the very poor or poor households that receive government support or subsidy (for people in this category, medical fees are waived (paid by the state). As of 2018, the Japanese state spent 10.9% of the GDP on health care. The healthcare provision in Japan is public and private. There are multiple insurance schemes, largely the state National Health Insurance (Kokumin-Kenkō-Hoken), the employees' or workers' Health Insurance (Kenkō-Hoken) and the employers' -based health insurance schemes.

In Thailand, the first attempt at health insurance was the scheme to cater for the welfare of the poor and vulnerable Thais in 1975. Thailand has made a lot of progress towards achieving UHC since the adoption of the Universal Coverage Scheme (UCS) in 2002, in which the citizens have free access to healthcare services under the auspices of the Ministry of Public Health (MOPH). It is funded by the government (65%) and by private sources (35%). Healthcare access seems to be more prevalent in the urban areas and less prevalent in the rural parts of Thailand. The UCS, also known as the "gold card or 30-baht scheme", has a population coverage of 99.5%. It is funded by state-public revenues, with 4.3% of GDP on health. However, the UCS has funding challenges, including sustainable funding for the poor and the vulnerable across Thailand. Brazil is another developing country that has made a lot of progress on UHC, and all persons, including foreigners with legal residence, have free access to healthcare services in Brazil. Brazil's national health system is "Sistema Único de Saúde (SUS)"- Unified Health System (SUS). It started in 1988. Healthcare services are provided by both public and private health facilities or institutions. The federal Constitution of 1988 made healthcare a legal right of the people of Brazil. However, there are challenges in terms of access to healthcare services in many rural areas. Singapore, last but not least, is one of the countries in the developing world that have success stories on UHC for the people. The services are provided largely by the private sector (66%) and the state (public), which is co-funded by employers and employees and government subsidies. There is efficient service delivery as well as quality healthcare services. Singapore spent 3.4% of its GDP on healthcare. Singapore's healthcare system on UHC is making strides in Southeast Asia.

DISCUSSION

Rwanda formulated the health insurance policy to make healthcare services free and accessible to all its citizens, as well as persons with legal residence. The health insurance policy is known as Mutuelles de Sante (community-based health insurance (CBHI), which covers most of the Rwandan population. There are other government health insurance schemes, which include the Rwanda Social Security Board (RSSB) and the Military Medical Insurance (MMI). These schemes cover government workers or employees (formal sector who pay 15% of their Basic Salaries, which is shared equally between the employers and the employees) while the rest of the population (informal sector including the poor and the vulnerable ones in society) is covered by Mutuelles de Santé [29]. The Rwandan health insurance policy embraces a public-private mix (organisations). Community-based health insurance (CBHI) provides 80-90% of the population's coverage [30-33]. The policy makes healthcare services free for the poorest while the rich in society pay annual premiums (8256.41 Rwandan francs, an equivalent of $8 United States (US) Dollars) [28]. The financing mechanisms include contributions from members, government subsidies, foreign donors/external sources of funds and sources of funds from other health insurance schemes.

Since 2008, health insurance has been mandatory for all, and the Rwandan government spent 9.7% of its GDP on health. Also, Rwanda has a population of 12.9 million and a GDP of 837 USD as of 2019 [33]. The Rwandan CBHI has reduced out-of-pocket payments by patients at health facilities, which account for 10%, thus increasing healthcare service utilisation in Rwanda due to the CBHI policy [34]. Despite the strong political will toward UHC, the country is faced with financial and human resource shortages, especially among medical doctors or practitioners. The sustainability of the CBHI remains the

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greatest challenge. This implies that for Rwanda to meet the ultimate goal of the global agenda of UHC by 2030, the Rwanda government has to diversify the sources of funding and increase the percentage of health spending. Such a move, if carried out more rigorously and effectively, should bring Rwanda very close to meeting or achieving the UHC by 2030. Historically, Tanzania's first attempt to provide healthcare services for all people was in 1987 through the Arusha Declaration ('Azimio la Arusha' in Swahili). Implementation was hampered due to rising costs of healthcare services, and it was only in the 1990s that a cost-sharing version of healthcare financing was adopted in the fashion of African Socialism, one people or oneness of the people or the 'Ujamaa', or brotherhood, everyone life is essential.

However, there were problems with the cost-sharing health reform, including inequity between the rich and the poor. Tanzania has multiple national health insurance schemes, some of which are private ones. Moving towards UHC, the Tanzania government adopted the Fourth (4th) Health Sector Strategic Plan (2015-2020) to address the challenges of access and to achieve healthcare for all [35-38]. The multiple schemes in Tanzania are a setback to the country's move towards achieving UHC due to variations in costs, population coverage, and healthcare services offered to patients. The National Health Insurance Fund (NHIF), established in 1999, is public and covers 13% of the population, and the Community Health Funds (CHF) covers 9% of the population. In all the categories of health insurance schemes, a total of 32% of Tanzanians are covered (insured), which is about one-third of the population as of 2019.

Tanzania spent 3.83 % of its GDP on health from 2000 - 2019 [42]. The other health insurance includes Private Health Insurance (PHI), which has a different benefits package and a fixed premium for members. The private micro-insurance sector covers only 1% of the population. There are other employer-employee schemes in Tanzania, a country with a population of 57.5 million [35-37]. The health sector or health insurance schemes are funded largely by government subsidies and external support such as the United States (US) government through the United States Agency for International Development (USAID) and the US Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) expected and these sources are complemented by the private sources and the development plan 2022 - 2026 to make free health services accessible to all [35,36,38-39]. Tanzania's moves towards achieving UHC by 2023 imply the need for a possible merger of the multiple schemes with a central authority and the government to adopt policy measures to increase health budget/spending. South Africa has taken steps to make healthcare services accessible to all citizens and persons with legal residence. The pathway toward UHC started in 2011 when the health minister (Aaron Motsoaledi) initiated a National Health Insurance (NHI) for South Africa. It is important to note this scheme does not cover all the people of South Africa, as there are two parallel schemes in the country. One scheme is for the public, and the other is for the private healthcare system. The health insurance system in South Africa is complex in terms of access to healthcare services, the mode of payments, and other related issues, such as nationality and income level. The 2011 NHI policy targets a single fund, and access to free healthcare services is based on constitutional rights and not on membership in NHI. The NHI policy aims to decrease cash payments at the points of healthcare service delivery [40-41]. South Africa's move towards UHC spent 8.5% of GDP on healthcare (R332 billion), and about half of the money was spent on the private sector largely in favour of the socioeconomic and political elites, a minority group representing 16% while a majority of people of South Africa representing 84% healthcare services needs depend on the public sector which is under-resourced or underfunded [40,43].

South Africa relies on the pathways towards UHC, and these include NHI and Primary Health Care (PHC) reengineering [40]. It is based on public-private mix providers for 14 years to achieve UHC from 2012-2026 [44]. The healthcare system of South Africa is faced with many challenges, including bridging the wide gap between the rich and the poor and how to deal with the disease burden of TB, HIV/AIDS, violence, and trauma, among others. These are the financing mechanisms for the pathway toward UHC in South Africa, namely a unified health financing system, movement from voluntary contributions to a more mandatory prepayment system, improvement in cross-subsidisation, public-private providers mix and need for the broader tax base for more revenues [40, 44]. This implies that the biggest challenge for South Africa towards achieving UHC is how to effectively deal with the gap between the rich and the poor, where the majority of the people rely on the public-funded scheme, which is largely under-resourced. Thus, there is a need to support the majority scheme with more funds.

Ghana adopted the National Health Insurance Scheme (NHIS) in 2003, which was implemented in 2004 to increase access to basic health care services for Ghanaians and other persons with legal residence in Ghana. The NHIS is funded by the state/government and other sources, including private sources. It is a state-centred health insurance policy which has since been funded locally from diverse sources within Ghana [21,45-47]. Also, Ghana, as of 2019, spent 3.49% of its GDP on health [48], and the NHIS, as of 2019, covered 40% of the population of Ghana [49-50]. The biggest threat to Ghana's NHIS is funding with lots of delays in payments of health service providers/facilities, thus sustainable financing through increased budgetary allocations for NHIS since most of the beneficiaries are exempted from payments of the annual premium. All four Sub-Saharan African states have health insurance schemes that aim to achieve UN SDG3.8 on UHC within the timelines of the global agenda (by 2030). While Rwandan community-based health insurance has the highest population coverage, Ghana is the second Sub-

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Saharan African state to achieve slightly more than 40% population coverage ahead of Tanzania and South Africa as of 2019. In terms of budgetary allocation or public funding of 2019 for the health sector, the findings suggest that Rwanda has the highest health spending at 9.7% of the GDP [33], followed by South Africa with 8.5% of GDP on healthcare (R332 billion) [40,43] with Tanzania and Ghana at the bottom 3.83 % of its GDP on health for Tanzania from 2000- 2019 [42] and Ghana spent 3.49% of its GDP on health [48].

From our findings, it is obvious that Rwanda is on the pathway towards achieving the global agenda (UN SDG 3.8 on UHC) more than the other three countries per the two indicators used, namely population coverage and public spending for the health sector. These findings show that Sub-Saharan African states need to invest more in health and spend more money on healthcare services to achieve UHC for all people/citizens. The inability of this research to strictly comply with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines is a limitation. Also, the sole use of secondary data sources could not reflect the citizens' feelings, views and experiences of the four countries about their health insurance schemes and their health policy strategies towards achieving the global agenda (the United Nations SDG 3.8) by 2030. Primary data sources should be added to the same area to reflect the real perspectives of the people in the four countries. Efforts should be made to reflect on PRISMA guidelines in future research on this social phenomenon.

Conclusion

Funding various health insurance schemes in most developing countries, especially in Africa, remains a challenge. The pathway to achieving UHC by 2030 is most likely to be missed by the four African states studied. Rwanda has the best coverage for UHC. It is therefore recommended that adequate funding and a positive attitude towards publicly funded health services be addressed to sustain African health insurance schemes/policies. A change of attitude to embrace the various health insurance schemes or policies across Africa may protect schemes against abuses.

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REFERENCES

1. Wyllie J, Carlson J, Heinsch M, Kay-Lambkin F, McCoy A (2022) eHealth services and SDG3: Increasing the capacity of care. Australasian Marketing Journal. 30:131-41.
2. United Nations Sustainable Development Goals (2021) Goal 3 ensures healthy lives and promotes well-being for all at all ages: Goal 3 targets
3. Asi YM, Williams C (2018) The role of digital health in making progress toward Sustainable Development Goal (SDG) 3 in conflict-affected populations. International journal of medical informatics. 114:114-20.
4. WHO. Constitution of the World Health Organization. Geneva: World Health Organization; 2005.
5. Howden-Chapman P, Siri J, Chisholm E, Chapman R, Doll CN, Capon A. (2017) SDG 3: Ensure healthy lives and promote well-being for all at all ages. A guide to SDG interactions: from science to implementation. Paris, France: International Council for Science. 81-126.
6. United Nations Sustainable Development Goals 3 (2022) good health and well-being (Ghana) https://ghana.un.org/en/sdgs/3. 2022, August 8, 2022.
7. World Health Organization (2022) https://www.who.int/health-topics/universal-health-coverage#tab=tab_1. 2020, August 9, 2022.
8. The World Bank (2022) Universal Health Coverage. https://www.worldbank.org/en/topic/universalhealthcoverage. August 9, 2022.
9. Van Minh H, Pocock NS, Chaiyakunapruk N, Chhorvann C, Duc HA, Hanvoravongchai P, et al. (2014) Progress toward universal health coverage in ASEAN. Glob Health Action 7:25856.
10. Umeh CA (2018) Challenges toward achieving universal health coverage in Ghana, Kenya, Nigeria, and Tanzania. Int J Health Plann Manage 33:794-805.
11. Darrudi A, Khoonsari MH, Tajvar M (2022) Challenges to achieving universal health coverage throughout the world: a systematic review. Journal of Preventive Medicine and Public Health. 55:125.
12. Craig AT, Beek K, Gilbert K, Soakai TS, Liaw ST, Hall JJ (2022) Universal Health Coverage and the Pacific Islands: An Overview of Senior Leaders' Discussions, Challenges, Priorities and Solutions, 2015–2020. International journal of environmental research and public health.19:4108.
13. Matheson D, Park K, Soakai TS (2017) Pacific Island health inequities forecast to grow unless profound changes are made to health systems in the region. Aust. Health Rev. 41:590–598.
14. Craig AT, Kaldor J, Schierhout G, Rosewell AE (2020) Surveillance strategies for the detection of disease outbreaks in the Pacific Islands: Meta-analysis of published literature, 2010–2019. Trop. Med. Int. Health 25:906–918.

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15. Ho CJ, Khalid H, Skead K, Wong J (2022) The politics of universal health coverage. The Lancet 399:2066-2074

16. Ghebreyesus TA (2017) All roads lead to universal health coverage. Lancet Glob Health 5: e839–40.

17. Kipo-Sunyehzi DD, Ayanore MA, Dzidzonu DK, AyalsumaYakubu Y (2019) Ghana's Journey towards universal health coverage: the role of the national health insurance scheme. European Journal of Investigation in Health, Psychology and Education 10:94-109.

18. Kipo-Sunyehzi DD (2021) Quality healthcare services under National Health Insurance Scheme in Ghana: perspectives from health policy implementers and beneficiaries. Public Administration and Policy.

19. Fuller J (1997) Multicultural health care: reconciling universalism and particularism. Nursing Inquiry 4:153-159.

20. Takura T, Miura H (2022) Socioeconomic determinants of universal health coverage in the Asian region. International journal of environmental research and public health. 19:2376.

21. Lagomarsino G, Garabrant A, Adyas A, Muga R, Otoo N (2012) Moving towards universal health coverage: Health insurance reforms in nine developing countries in Africa and Asia. Lancet 380:933–943.

22. Countries with Universal Health Care: https://worldpopulationreview.com/country-rankings/countries-with-universal-healthcare Accessed August 11, 2022.

23. McKee M, Balabanova D, Basu S, Ricciardi W, Stuckler D (2013) Universal health coverage: a quest for all countries but under threat in some. Value in Health. 6:S39-45.

24. Darrudi A, Khoonsari MH, Tajvar M (2022) Challenges to achieving universal health coverage throughout the world: a systematic review. Journal of Preventive Medicine and Public Health. 55:125.

25. Kutzin J (2013)Health financing for universal coverage and health system performance: concepts and implications for policy. Bull World Health Organ.91:602–611.

26. Kutzin J, Witter S, Jowett M, Bayarsaikhan D (2017) World Health Organization. Developing a national health financing strategy: a reference guide. 2017.

27. Ifeagwu SC, Yang JC, Parkes-Ratanshi R, Brayne C (2021) Health financing for universal health coverage in Sub-Saharan Africa: a systematic review. Global health research and policy. 6:1-9.

28. Currency Converter. https://www.xe.com/currency converter /Accessed 21 August 2022.

29. Karara G, Verbeke F, Nyssen M (2015) The Role of Hospital Information Systems in Universal Health Coverage Monitoring in Rwanda. InMedInfo :193-197.

30. Makaka A, Breen S, Binagwaho A (2012) Universal health coverage in Rwanda: a report of innovations to increase enrolment in community-based health insurance. The Lancet. 380:S7.

31. Community Based Health Insurance Law, Rwanda CBHI. Kigali Rwanda. 2015.

32. Chirwa GC, Suhrcke M, Moreno-Serra R (2021) Socioeconomic inequality in premiums for a community-based health insurance scheme in Rwanda. Health Policy and Planning 36:14-25.

33. Umuhoza SM, Musange SF, Nyandwi A, Gatome-Munyua A, Mumararungu A, Hitimana R, Rulisa A, Uwaliraye P (2022) Strengths and weaknesses of strategic health purchasing for universal health coverage in Rwanda. Health Systems & Reform. 8:e2061891.

34. Koch R, Nkurunziza T, Rudolfson N, Nkurunziza J, Bakorimana L, Irasubiza H, Sonderman K, Riviello R, Hedt-Gauthier BL, Shrime M, Kateera F (2022) Does community-based health insurance protect women from financial catastrophe after cesarean section? A prospective study from a rural hospital in Rwanda. BMC Health Services Research. 22:1-1.

35. Universal Health Coverage in East Africa Report by Medic East Africa https://www.mediceastafrica.com/en/overview /industry-insights/universal-health-coverage-in-east-africa /tanzania.html Accessed 23 August 2022.

36. Tanzania - Country Commercial Guide https://www.trade.gov/country-commercial-guides/tanzania-healthcare Accessed 23 August 2022.

37. Kapologwe NA, Meara JG, Kengia JT, Sonda Y, Gwajima D, Alidina S, Kalolo A (2020) Development and upgrading of public primary healthcare facilities with essential surgical services infrastructure: a strategy towards achieving universal health coverage in Tanzania. BMC Health Services Research. 20:1-4.

38. Bech M, Lawi Y, Massay D, Rekdal O (2013)Changing policies and their influence on government health workers in Tanzania, 1967–2009: perspectives from rural Mbulu District. Int J Afr Hist Stud. 46:61–103.

39. Kimario KA, Muhanga MI, Kayunze KA (2020) Household Socio-demographic Characteristics and Progress towards Attainment of Universal Health Coverage in Kilimanjaro, Tanzania. medRxiv.

40. Michel J, Tediosi F, Egger M, Barnighausen T, McIntyre D, Tanner M, Evans D (2020) Universal health coverage financing in South Africa: wishes vs reality. Journal of Global Health Reports. 21;4:e2020061.

41. Witter S, Anderson I, Annear P et al. (2019) What, why and how do health systems learn from one another? Insights from eight low- and middle-income country case studies. Health Res Policy Sys. 17.

42. World Health Organization Global Health Expenditure database (% of GDP - Tanzania) https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=TZ Accessed 23 August 2022.

43. Rispel L. Faultlines in delivering good health care to poor people in South Africa. The Conversation.

44. http://theconversation.com/faultlines-in-delivering-good-health-care-to-poor-people-in-south-africa-48329 Accessed August 23, 2022.

45. National Health Act, 2003: White Paper on National Health Insurance https://www.gov.za/sites/default/files/gcis_document/201512/39506gon1230.pdf Accessed August 23, 2022.

46. Kipo-Sunyehzi DD, Ayanore MA, Dzidzonu DK, AyalsumaYakubu Y (2019)Ghana's Journey towards universal health coverage: the role of the national health

insurance scheme. European Journal of Investigation in Health, Psychology and Education. 10:94-109.

47. Arhin AA (2013) Promising start, but bleak future? Progress of Ghana's national health insurance schemes towards universal health coverage. Developing Country Studies. 3:151-159.

48. Ghanbari MK, Behzadifar M, Doshmangir L, Martini M, Bakhtiari A, Alikhani M, Bragazzi NL (2021) Mapping research trends of universal health coverage from 1990 to 2019: bibliometric analysis. JMIR Public Health and Surveillance. 17:e24569.

49. Ghana Healthcare Spending 2000-2023 (2022) https://www.macrotrends.net/countries/GHA/ghana/health care-spending (Accessed August 24, 2022)

50. Fenny AP, Yates R, Thompson R (2021) Strategies for financing social health insurance schemes for providing universal health care: a comparative analysis of five countries. Global Health Action.14:1868054.

51. Kipo-Sunyehzi DD (2021) Global social welfare and social policy debates: Ghana's Health Insurance Scheme promotion of the well-being of vulnerable groups. Journal of Social Service Research. 47:73-87.

52. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, Shamseer L, Tetzlaff JM, Akl EA, Brennan SE, Chou R. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. Bmj. 2021 Mar 29;372.

53. Sohrabi C, Franchi T, Mathew G, Kerwan A, Nicola M, Griffin M, Agha M, Agha R. PRISMA 2020 statement: what's new and the importance of reporting guidelines. International Journal of Surgery. 2021 Apr 1;88:105918.

54. Park HY, Suh CH, Woo S, Kim PH, Kim KW. Quality reporting of systematic review and meta-analysis according to PRISMA 2020 guidelines: results from recently published papers in the Korean Journal of Radiology. Korean journal of radiology. 2022 Mar;23(3):355.